

MDR Tracking Number: M5-04-3764-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-01-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the office visits, manual therapy, ultrasound, and electrical stimulation services rendered from 10/02/03 through 10/08/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 23, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for **CPT code 95900** (2 nerves) on date of service 7/22/03. The carrier denied this service with an "F"—fee guideline reduction but no payment was made. **Reimbursement is recommended** in the amount of \$128.00 in accordance with the 1996 Medical Fee Guidelines.

In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service for **CPT code 95904** (3 nerves) on date of service 7/22/03. The carrier denied this service with an "F"—fee guideline reduction but no payment was made. The requestor billed \$112.50 and therefore, **reimbursement is recommended** in the amount of \$112.50.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to date of service 7/22/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 4<sup>th</sup> day of October 2004.

Regina L. Cleave  
Medical Dispute Resolution Officer  
Medical Review Division

September 9, 2004

Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-04-3764-01  
TWCC#:  
Injured Employee:  
DOI:  
SS#:  
IRO Certificate No.: 5055

Dear

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

## REVIEWER'S REPORT

### Information Provided for Review:

TWCC-60, Table of Disputed Services, EOB's

Information provided by Requestor: office notes, treatment logs, evaluations, referrals, consults, radiology (07/31/02–10/08/03).

Information provided by Respondent: correspondence, evaluations and hand therapy notes (04/16/03-10/08/03).

*(It should be noted that documentation was submitted of services and treatment rendered after the dates in dispute. This documentation was not submitted to the reviewer.)*

### Clinical History:

The patient underwent surgery, injections and physical medicine treatments after sustaining an on-the-job injury to her left upper extremity on \_\_\_\_.

### Disputed Services:

Office visits, manual therapy, ultrasound and electrical stimulation during the period of 10/02/03 through 10/08/03.

### Decision:

The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

### Rationale:

Although the medical necessity of an additional injection was questionable, it was nevertheless performed. Since that procedure was accomplished, the question before the reviewer was whether or not the post injection therapy was medically necessary.

In this case, the treating doctor could have predicted the claimant's lack of response since the patient had failed to benefit from previously attempted post-injection treatment. Specifically, after previous injections, the patient's pain rating did not improve as a result of the treatment provided. Based on those failed attempts, it was neither indicated nor medically necessary to repeat treatments that had not been successful in the past.

The records fail to substantiate that the aforementioned services fulfilled the requirements of Texas Labor Code 408.021 since the patient obtained no relief, promotion of recovery was not accomplished and there was no enhancement of her ability to return to employment.

Sincerely,